DPHHS-AMDD-33-002
(New 08/10)

FAX TO: ***MOUNTAIN PACIFIC QUALITY HEALTH*** **FAX #:** ***1-800-413-3890 or (443-4585-Helena area)***
FROM: _____ **Date**_____

STATE OF MONTANA
Department of Public Health and Human Services

HOME AND COMMUNITY BASED SERVICES for ADULTS WITH SEVERE DISABLING MENTAL ILLNESS DISCHARGE SHEET

Individual Name: _____ _____
(Last) (First)

Individual Medicaid Id#: _____ **Case Management Team No.:** _____

County Where Individual Resided:_____

Most Recent Admit Date: _____ **Discharge Date:** _____

Eligibility Worker Sent Discharge Notice: Yes_____ **No**_____

DISCHARGE CODE: (Circle One)

1	**Death**	**8**	**Voluntary Disenrollment**
2	**Nursing Home Placement**	**9**	**Other (Specify)** _____
3	**Hospital Placement**		_____
4	**No Longer Requires Services**	**10**	**No Longer Meets Level of Care**
5	**Medicaid Ineligibility**	**11**	**Care Category Change***
6	**Moved From Service Area**	**12**	
7	**Exceeded Cost Limit**	**13**	**Year End Money**
		15	**Psychiatric Hospitalization**

Signature: _____ **Date:** _____